DOCUMENT RESUME

ED 414 025 PS 025 980

TITLE	Special Early Childhood Report, 1997.
INSTITUTION	National Education Goals Panel, Washington, DC.
PUB DATE	1997-10-00
NOTE	42p.
AVAILABLE FROM	National Education Goals Panel, 1255 22nd Street, Suite 502, Washington, DC 20037 (Catalog No. 98-01, free).
PUB TYPE	Numerical/Quantitative Data (110) -- Reports - Descriptive (141)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Child Health; *Early Childhood Education; *Early Experience; Early Intervention; *Educational Improvement; *Educational Objectives; Educational Policy; Family Role; Learning Readiness; Parent Role; Parent School Relationship; Parents as Teachers; Social Indicators; State Programs; State Standards; Well Being
IDENTIFIERS	*National Education Goals 1990

ABSTRACT

This report focuses on the first goal of the National Education Goals--that all children will arrive at school ready to learn. The report presents data indicating the status of young children at the start of the three year "I Am Your Child" campaign, and the progress of the nation and states toward meeting the health, family, and preschool objectives associated with Goal One. These data are supplemented with new information about children from birth to age 2. Part 1 of the report discusses the policy context of Goal One, and the need for immediate action in ensuring the welfare of young children. Part 2 of the report presents data related to 10 social indicators: (1) prenatal care; (2) birthweight; (3) children's health index; (4) immunizations; (5) family-child reading; (6) other family-child language and literacy activities; (7) support for families of preschoolers; (8) preschool participation; (9) quality of preschool centers; and (10) the quality of home-based preschool settings. (JPB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

SPECIAL EARLY CHILDHOOD REPORT 1997

ED 414 025

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

- [x] This document has been reproduced as received from the person or organization originating it.
- [ ] Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PS 025980

BEST COPY AVAILABLE

National Education Goals Panel

Governors

James B. Hunt, Jr., North Carolina (Chair, 1997)
John Engler, Michigan
William Graves, Kansas
Paul E. Patton, Kentucky
Roy Romer, Colorado
Tommy G. Thompson, Wisconsin
Cecil Underwood, West Virginia
Christine Todd Whitman, New Jersey

Members of the Administration

Carol H. Rasco, Senior Advisor to the Secretary of Education
Richard W. Riley, Secretary of Education

Members of Congress

U.S. Senator Jeff Bingaman, New Mexico
U.S. Senator Jim Jeffords, Vermont
U.S. Representative William F. Goodling, Pennsylvania
U.S. Representative Dale E. Kildee, Michigan

State Legislators

Representative G. Spencer Coggs, Wisconsin
Representative Ronald Cowell, Pennsylvania
Representative Mary Lou Cowlishaw, Illinois
Representative Douglas R. Jones, Idaho

National Education Goals Panel Staff

Ken Nelson, Executive Director
Leslie A. Lawrence, Senior Education Associate
Cynthia D. Prince, Associate Director for Analysis and Reporting
Emily O. Wurtz, Senior Education Associate
Cynthia M. Dixon, Program Assistant
John Masaitis, Executive Officer

October 1997

SPECIAL EARLY CHILDHOOD REPORT 1997

Goal 1: Ready to Learn

By the year 2000, all children in America will start school ready to learn.

Objectives:

- All children will have access to high-quality and developmentally appropriate preschool programs that help prepare children for school.
- Every parent in the United States will be a child's first teacher and devote time each day to helping such parent's preschool child learn, and parents will have access to the training and support parents need.
- Children will receive the nutrition, physical activity experiences, and health care needed to arrive at school with healthy minds and bodies, and to maintain the mental alertness necessary to be prepared to learn, and the number of low-birthweight babies will be significantly reduced through enhanced prenatal health systems.

Part 1. Introduction

The National Education Goals Panel believes that all children should start school ready to learn and that the success of the nation rests squarely on our ability to do well by the very young. In 1990, the President and state Governors established their first National Education Goal: that by the year 2000, all children in America will start school ready to learn. In 1997, a broad coalition of educators, community activists, and early childhood advocates and specialists launched a 3-year public engagement campaign, *I Am Your Child*, to increase public support to do better by our youngest children, from birth to age 3.

The Goals Panel applauds that campaign and supports it by issuing this special report, its first ever focused on a single Goal. In it are data indicating the status of young children at the start of the 3-year *I Am Your Child* campaign and the progress of the nation and states at meeting the health, family, and preschool objectives associated with Goal 1.

Policy Context

All parents want the best for their children, and all communities want good outcomes for the children and families who live there. Traditionally, families have provided the early care and education for their children that their parents provided for them. When parents needed help, the extended family and friends did their best to provide it.

Changes in the patterns of our private lives have created an urgency to provide a better and more comprehensive system of care and early education for young children. Fewer children live in families with two parents. Significant numbers of young children live in poverty, with inadequate health care, or in families contending with social conditions and parental choices that put substantial stress on the adults and children involved. A majority of parents now work full- or part-time outside the home before their children begin school, and the dual demands to be good parents and good workers are not easily balanced. A majority of children under 3

spend substantial amounts of time outside their own homes, cared for by non-relatives, as their parents, in rich and poor families alike, juggle their responsibilities.

As a result, the demand for child care and early education has grown dramatically. This demand is likely to increase for two reasons. First, demographic trends indicate that the numbers of preschool-aged children with mothers in the workforce are likely to increase. Second, new welfare policies which require all able-bodied adults to enter the workforce within a few years of welfare receipt — including those with young children — are also likely to increase the demand for early care and education.

Most families make provision for the care of their children at considerable financial and emotional cost to themselves. Transporting young children to and from child care and making alternative provisions for them when they are sick have becom · familiar demands on young families. The costs of early care and edu ation are subsidized only for low-income families, and these costs fall on most families at the beginning and most poorly paid stage of their work lives.

Even then, it is not easy to find openings in good early care programs. Only a percentage of those who qualify for Head Start are served by the program. Many states and religious groups provide additional programs for low-income children, but only rarely are the preponderance of eligible children in a community served. Even those able to pay can have difficulty finding facilities in which they can be certain of a high-quality program — those that early childhood experts consider to have adequate staff training, group size, and adult-to-child ratios.

Popular attitudes are in transition regarding the importance of these issues and how best to deal with them. The care of young children has always been seen as important in shaping the kinds of adults that children become. Research in child development, language acquisition, cognitive development, and, more recently, early brain development, all reinforce the view that children's earliest experiences influence the course of their subsequent development. How they are nurtured — talked with, played with, responded to, allowed to explore, and encouraged to express themselves — is formative for subsequent learning and the kinds of people they will be.

Despite increased awareness that the quality of children's earliest interactions with adults matter enormously, mothers' helpers and child care workers are typically very poorly paid, in part because the day-to-day labor involved has been seen as mindless and unskilled. Because the care of young children is so clearly thought to be the responsibility of their parents, the provisions that parents have made for this care when it occurs outside the home have not been overseen or supported by any external agency. Distinctions between the roles of baby-sitters, day care workers,

and preschool teachers are vaguely understood, and the need for training and professional development for staff and licensing of centers has only recently been recognized. The resulting pattern of current child care is a hodgepodge of ad hoc arrangements without coherence or quality control.

Time for Action

A consensus is emerging that this hodgepodge is intolerable. The first National Education Goal and the *I Am Your Child* campaign urge that the welfare of young children be made an immediate priority. Aggressive action is needed to improve the current system.

In order to succeed, serious barriers will have to be overcome. The current system is fragmented among a staggering number of federal, state, and local agencies with varying eligibility and staff requirements; program rules and regulations; and accountability mechanisms. Old funding sources are insufficient to meet current demands. Part-day, part-year programs serving only 3- to 5-year-olds need to be modified to meet the needs of parents in the workforce. New ways are needed to support families and ensure their access to health care for their children. While both the K-12 and higher education systems have developed public/private oversight bodies, no equivalent governance structures exist for a community's early childhood programs.

Policymakers are taking action. States are expanding traditional program services for young children, seeking new ways to make them accessible and affordable, and developing mechanisms to remove barriers and assure higher quality and more flexible and comprehensive services for families and children at the local level. Some communities are forming local councils parallel to local school boards to coordinate and oversee services for preschool-aged children in their communities.

Hundreds of local, state, and national organizations concerned about young children have joined the *I Am Your Child* campaign to increase public awareness of the importance of the first years of life and to urge further action to improve the conditions of children from birth to age 3. The campaign urges parents of young children to be warm, loving, and responsive; respond to the child's cues and clues; talk, sing, and read to your child; establish rituals and routines; encourage safe exploration and play; make television watching selective; use discipline as an opportunity to teach; recognize that each child is unique; choose quality child care and stay involved; and take care of yourself. With private corporate funds, the campaign expands upon these themes in a booklet and video for parents, a CD-ROM, and other materials that are available by writing *I Am Your Child*, 1010 Wisconsin Avenue, NW, Suite 800, Washington, DC 20007, or by calling 202-338-4385.

Hundreds of early childhood specialists have developed a report, *Not By Chance: Creating an Early Care and Education System for American Children*, to express a long-range vision for the early care and education field. Composed of eight policy recommendations, the report addresses ways to improve program quality, the training and credentialing of workers, and the regulation, financing, and governance of the field. Copies of the report will be available in the fall of 1997. For further information, contact the Bush Center in Child Development and Social Policy, Yale University, 310 Prospect Street, New Haven, CT 06511-2188, telephone 203-432-9931.

Measuring Results

What effects will such efforts have? The campaign can already point to an impressive array of products and coordinated public information activities, from repeat broadcasts of the hour-long ABC *I Am Your Child* special to a special edition of *Newsweek* on "Your Child from Birth to Three." Complementing these activities, the Goals Panel reports data every year about the welfare of children. Part 2 of this report, Indicators of the Well-Being of Young Children, explains how the Goals Panel measures the current status of children and the progress that the nation and states are making to improve their well-being; what these data now show; and the direction in which these indicators must change to measure the results of the *I Am Your Child* campaign and the efforts of the National Education Goals Panel.

TIPS FOR PARENTS

1. Be warm, loving, and responsive. When children receive warm, responsive care, they are more likely to feel safe and secure with the adults who take care of them.
2. Respond to the child's cues and clues. Recognize and respond to the sounds, movements, and expressions that your child makes. This will help you build secure attachments.
3. Talk, sing, and read to your child. All of these interactions help your child's brain make the connections it needs for growth and later learning.
4. Establish rituals and routines. Teach your child to know when it's time for bed by developing routines such as singing a song and pulling the curtains—daily routines and rituals associated with pleasurable feelings are reassuring for children.
5. Encourage safe exploration and play. As infants grow, they begin to explore the world beyond their caregivers. Parents should encourage this exploration. While many of us think of learning as simply acquiring facts, children actually learn through playing.
6. Make television watching selective. Watch television with your child, and talk about what you are viewing. Don't use TV as a baby-sitter.
7. Use discipline as an opportunity to teach. In addition to consistent and loving adult supervision, teach your child limits. Never hit or shake a child.
8. Recognize that each child is unique. Children grow at different rates. Their ideas and feelings about themselves reflect, in large measure, parents' and caregivers' attitudes towards them.
9. Choose quality child care and stay involved. Frequently visit your child care provider and seek someone who responds warmly and responsively to your baby's needs.
10. Take care of yourself.

Source: *I Am Your Child* campaign.

Part 2. Indicators of the Well-Being of Young Children

The National Education Goals Panel was created in 1990 to report national and state progress toward the National Education Goals, the first of which is that all children in America will start school ready to learn. The Panel struggled to define the elements of early learning and development thought to make a child ready to learn — health and physical development; emotional well-being and social development; approaches to learning; language use and communication skills; and cognition and general knowledge. Because no direct measures of these qualities currently exist, the National Education Goals Panel annually reports data regarding health, family activities, and preschool experiences — all measuring progress toward the three objectives associated with Goal 1.

This special Goal 1 report presents the latest data available on the full set of Goal 1 indicators, and supplements them with new information about children from birth to age 2. The chart on page 9 summarizes the data that are included in this report, and indicates whether the data presented are national-level or state-level and whether they measure children at birth to 2, or 3 to 5 years of age.

In the year 2000, the target date for attainment of the National Education Goals and the conclusion of the *I Am Your Child* campaign, the Panel plans to reissue this special report. It is our hope that we can then report more mothers receiving prenatal care; fewer infants born at low birthweight or with other health risks; more toddlers fully immunized; more parents reading and telling stories to their children; more supports and training for parents; greater access to day care and preschools; and higher quality day care and preschool services. The National Education Goals Panel and the *I Am Your Child* campaign working alone cannot guarantee such changes, but they are possible. Working together, Americans can make a difference for young children.

Indicators of National and State Progress toward Goal 1

	National data	State data	0- to 2-year-olds	3- to 5-year-olds
Health:				
1. Prenatal Care	X	X	X	
2. Birthweight	X	X	X	
3. Children's Health Index	X	X	X	
4. Immunizations	X	X	X	
Family-Child Activities:				
5. Family-Child Reading	X		X	X
6. Other Family-Child Language and Literacy Activities (storytelling and going to library)	X			X
7. Support for Families of Preschoolers	X			X
Preschool Experiences:				
8. Preschool Participation	X		X	X
9. Quality of Preschool Centers	X		X	X
10. Quality of Home-Based Preschool Settings	X		X	X

BEST COPY AVAILABLE

Health

Indicator 1. Prenatal Care

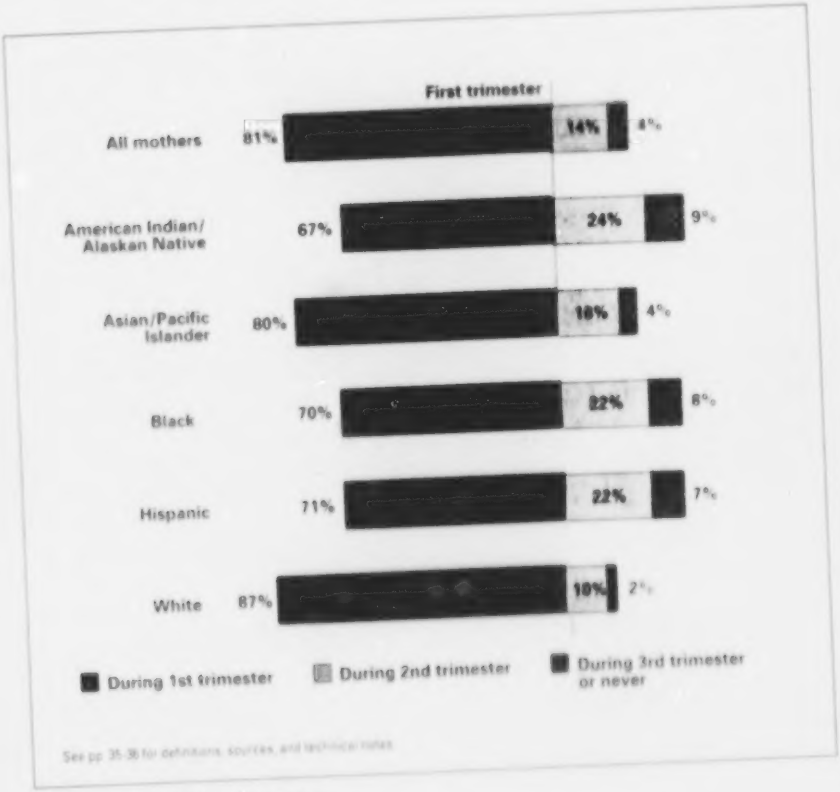
Parents play a critical role in achieving the National Education Goals, and parents' behavior (even before the birth of their children) can be an important determinant of how well their children will do in school. The first three months of pregnancy, or the first trimester, is the most critical period of fetal development. Mothers who receive early and continuous prenatal care are more likely to follow a nutritious diet; gain an adequate amount of weight; abstain from smoking, alcohol, drugs, and other harmful substances; and give birth to a baby who is above the standard for low birthweight (that is, at or above 5.5 pounds).

However, a mother who receives no prenatal care is three times more likely to deliver a low-birthweight baby than one who has received appropriate prenatal care.[1] The percentage of U.S. mothers who began prenatal care during their first trimester of pregnancy increased substantially in the late 1970s, but has leveled off since 1980. In 1995, 81% of all mothers received early prenatal care, compared to 87% for Whites, 80% for Asian/Pacific Islanders, 71% for Hispanics, 70% for Blacks, and 67% for American Indians/Alaskan Natives (see Exhibit 1).

The percentage of mothers who received early prenatal care in 1995 ranged from 90% in the best states to 60% in the worst states (see Table 1). The best states were New Hampshire and Rhode Island (both at 90%), Maine and Massachusetts (both at 89%), and Connecticut and Maryland (both at 88%).

Exhibit 1: Prenatal Care

Point at which mothers first began prenatal care in 1995



See pp. 35-36 for definitions, sources, and technical notes.

Percentages may not add to 100% due to rounding.

In 1995, 81% of mothers began prenatal care during their first trimester of pregnancy. 14% did not begin prenatal care until their second trimester; and 4% did not begin prenatal care until their third trimester or received no prenatal care at all.

BEST COPY AVAILABLE

Indicator 2. Birthweight

Infants are considered low birthweight if they weigh less than 5.5 pounds at birth, and very low birthweight if they weigh less than 3.3 pounds. Low birthweight is a condition that may increase a child's risk of developing health, learning, and behavioral problems later in life. In a study of children aged 4 to 17, children who were born at low birthweight were more likely to be enrolled in special education classes, to repeat a grade, or to fail school than children who were born at a normal birthweight.[2] Low birthweight is also a condition that disproportionately affects some racial/ethnic groups. Black infants are twice as likely as others to be born at low-birthweight, and among Hispanic subgroups, low birthweight is most common among Puerto Rican infants.[3]

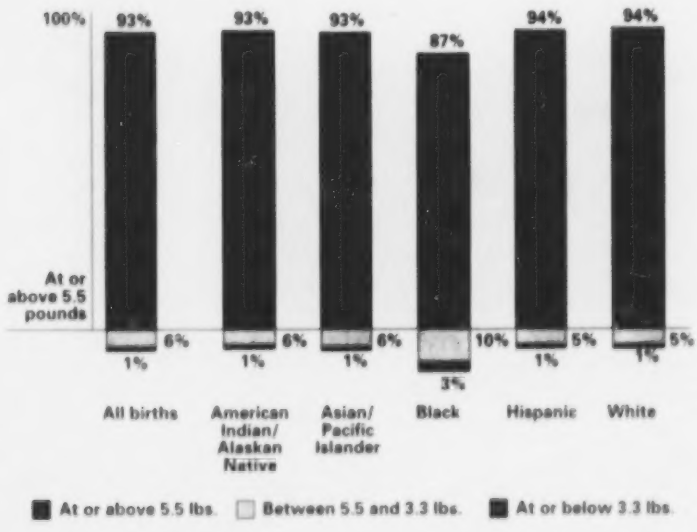
Factors that may contribute to low birthweight include low weight gain during pregnancy, alcohol consumption, illicit drug use, and smoking.[4] According to studies reviewed by the U.S. Department of Health and Human Services, smoking is associated with 20 to 30% of the low birthweight births in the United States.[5]

In 1995, 7% of all U.S. infants were born at low birthweight (see Exhibit 2). The proportion of low-birthweight infants was also 7% for American Indians/Alaskan Natives and Asian/Pacific Islanders, and 6% for Hispanics and Whites. The proportion of Black infants who were born at low birthweight, however, was 13%.

The percentage of infants born at low birthweight in 1995 ranged from 5% in the best states to 13% in the worst states (see Table 2). The best states were Alaska, North Dakota, Oregon, Vermont, and Washington (all at 5%).

Exhibit 2: Birthweight

Percentage of births above and below 5.5 and 3.3 pounds, 1995



See pp. 35-36 for definitions, sources, and technical notes.

In 1995, 93% of infants born in the United States were above the standard for low birthweight (5.5 pounds); 7% were below the standard. Black infants were twice as likely as those from other racial/ethnic groups to be born at low birthweight.

Indicator 3. Children's Health Index

In addition to tracking national and state progress on individual indicators of children's health at birth, the National Education Goals Panel tracks national and state progress on an index that combines several indicators of children's well-being. Four birth characteristics linked to children's later health, behavior, and academic achievement have been combined into a Children's Health Index to monitor the general status of the nation's children. The at-birth health risks are:

- Late (third trimester) or no prenatal care;
- Low maternal weight gain (less than 21 pounds);
- Mother smoked during pregnancy; and
- Mother drank alcohol during pregnancy.

It is important to note that while the Children's Health Index is a very useful population statistic for monitoring the general status of the nation's children, *it is not intended to be used as a predictor of any individual child's potential for school success*. Absence of the four at-birth health risks does not necessarily mean that a child will be well prepared for the challenges of formal schooling. Moreover, children who are born with one or more risks are not necessarily destined for academic failure. What is of increasing concern, however, is the proportion of children born in the United States with multiple risk factors, and the cumulative deleterious effects of those risk factors on their school performance.

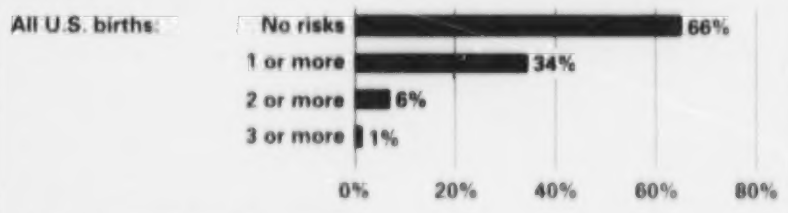
In 1995, 34% of all U.S. infants were born with one or more of the four health risks (see Exhibit 3). Six percent were born with two or more, and 1% were born with three or more. American Indian/Alaskan Native infants and Black infants were more likely than others to be born with one or more risks.

At the state level, the percentage of infants born in 1995 with one or more health risks ranged from 24% in the best states to 42% in the worst states (see Table 3). The best states, in which the smallest proportions of children were born with one or more risks, were Hawaii (24%), Connecticut (25%), and Maryland, Minnesota, New Jersey, and Texas, (all at 29%).

The promising news is that over time, the United States has been successful in reducing the proportion of infants born with one or more health risks. Between 1990 and 1995, the percentage has decreased from 37% to 34%, which represents a difference of at least 61,900 children who were born with a healthier start in life. Increased efforts by parents and by health and social service agencies will be required to reduce the proportions of at-risk infants still further.

Exhibit 3: Children's Health Index

Percentage of infants born in the U.S. with any of the following health risks: mother received late or no prenatal care; low maternal weight gain; smoking by mother during pregnancy; or alcohol use by mother during pregnancy, 1995



See pp. 35-36 for definitions, sources, and technical notes.

In 1995, about one-third of all infants born in the United States began life with one or more factors (such as low maternal weight gain or tobacco/alcohol use by their pregnant mothers) that are considered risks to their long-term health and educational development.

Indicator 4. Immunizations

One of the most important preventive actions parents can take to see that their children receive the "health care needed to arrive at school with healthy minds and bodies" specified in the third objective for this Goal, is to make certain that they are fully immunized against nine preventable childhood diseases: diphtheria, tetanus (lockjaw), pertussis (whooping cough), measles, mumps, rubella (German measles), polio, hepatitis B, and *hib* (*Haemophilus influenzae type b*, a cause of meningitis).

Measles, as the National Center for Health Statistics points out, is an example of a dangerous, yet preventable, disease that should be fairly easy for the United States to control because a vaccination has been available since 1963.[6] Immunizations against measles actually can help protect children against other diseases, malnutrition, and disabling conditions, such as deafness and blindness.[7] Yet despite the availability of a measles vaccine, outbreaks of measles increased sharply at the turn of the decade, from approximately 3,400 cases in 1988 to nearly 28,000 cases in 1990.[8]

Data collected by UNICEF indicate that the United States compares favorably to nations such as Japan, France, and Australia in the percentage of its 1-year-olds who are immunized against measles, but the U.S. is also at or below the measles immunization levels in a number of developing nations such as Pakistan, Thailand, Panama, Zimbabwe, and Colombia. Among industrialized nations, the U.S. ranks 21st out of 28.[9]

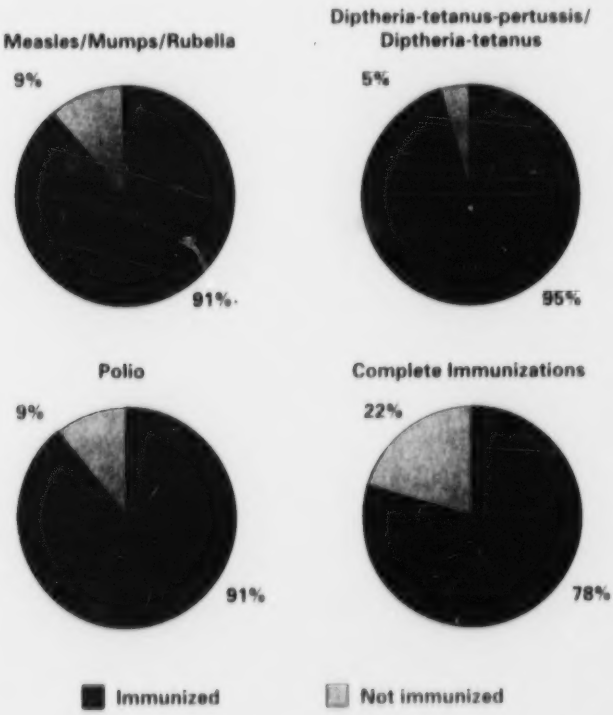
The American Academy of Pediatrics recommends a regular series of immunizations and booster shots to protect children completely against preventable diseases, beginning at birth and continuing through young adulthood. The good news is that by age 5 most children in the United States have been immunized, because immunizations are required by nearly all states for school entry. In 1990, child immunization rates at the time of entry into either kindergarten or first grade were 97% for polio and diphtheria-tetanus-pertussis, and 98% for measles, mumps, and rubella.[10]

However, the bad news is that only slightly more than three-fourths of younger U.S. children (between the ages of 1.5 and 3) were fully immunized in 1996 (see Exhibit 4). Increased efforts must target this age group because nearly all U.S. children have been weaned by this age and are no longer protected by their mothers' antibodies against infectious diseases.

At the national level, low-income children and Black children are less likely to be fully immunized than others, but each individual state and locality must determine which populations of children are at greatest risk in order to target their immunization efforts appropriately. The percentage of 2-year-olds who were fully immunized in 1996 ranged from 88% in the best states to 64% in the worst states (see Table 4). The best states were Connecticut (88%), and Maine and Massachusetts (both at 87%).

Exhibit 4: Immunizations

Percentage of 2-year-olds who completed their basic immunization series for selected diseases, 1996



See pp. 35-36 for definitions, sources, and technical notes.

In 1996, slightly more than three-fourths of all 2-year-olds had been fully immunized against major childhood diseases.

State Level Data

Table 1

Prenatal Care

National Average

In 1995, 81% of all U.S. mothers began prenatal care during their first trimester of pregnancy.

Best States

New Hampshire	90%
Rhode Island	90%
Maine	89%
Massachusetts	89%
Connecticut	88%
Maryland	88%

Range of States

In 1995, the percentage of mothers who began prenatal care during their first trimester of pregnancy ranged from 90% in the best states to 60% in the worst states.

Table 2

Birthweight

National Average

In 1995, 7% of all infants born in the U.S. were at low birthweight (below 5.5 pounds).

Best States

Alaska	5%
North Dakota	5%
Oregon	5%
Vermont	5%
Washington	5%

Range of States

In 1995, the percentage of infants born in the U.S. who were low birthweight ranged from 5% in the best states to 13% in the worst states.

State Level Data

Table 3

Children's Health Index

National Average

In 1995, 34% of all children were born with 1 or more health risks (mother received late or no prenatal care; low maternal weight gain; or smoking or alcohol use by mother during pregnancy).

Best States

Hawaii	24%
Connecticut	25%
Maryland	29%
Minnesota	29%
New Jersey	29%
Texas	29%

Range of States

In 1995, the percentage of children born in the U.S. with one or more health risks ranged from 24% in the best states to 42% in the worst states.

Table 4

Immunizations

National Average

In 1996, 78% of all 2-year-olds were fully immunized.

Best States

Connecticut	88%
Maine	87%
Massachusetts	87%

Range of States

In 1996, the percentage of 2-year-olds who were fully immunized ranged from 88% in the best states to 64% in the worst states.

BEST COPY AVAILABLE

Family-Child Activities

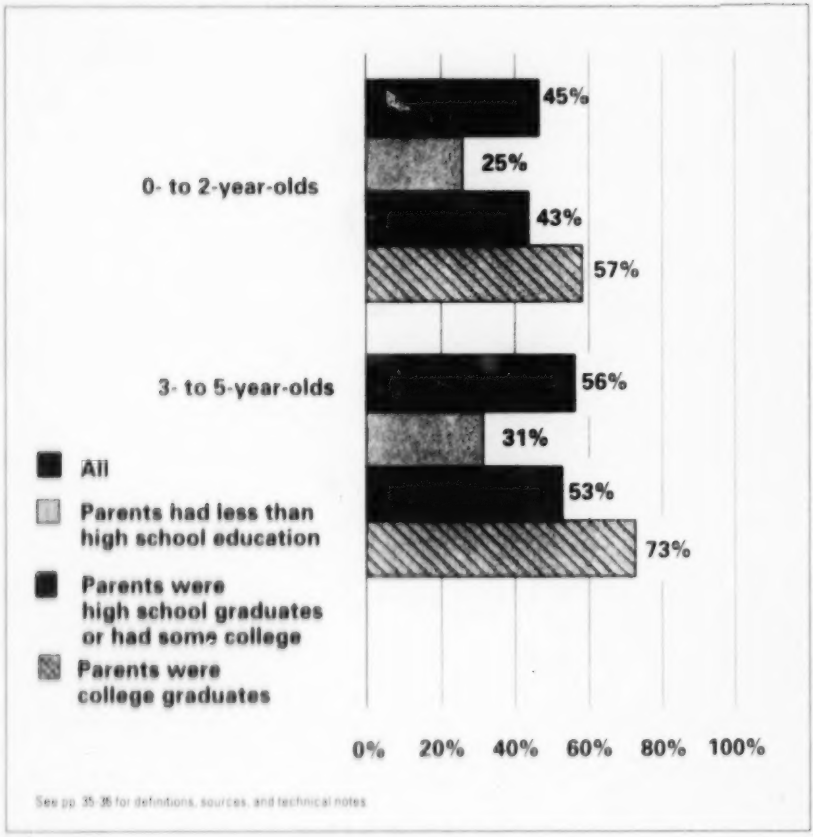
Indicator 5. Family-Child Reading

Early, regular reading to children is one of the most important activities parents can do with their children to improve their readiness for school, serve as their child's first teacher, and instill a love of books and reading. Reading to children familiarizes them with story components such as characters, plot, action, and sequence ("Once upon a time...," "...and they lived happily ever after"), and helps them associate oral language with printed text. Most important, reading to children builds their vocabularies and background knowledge about the world.

Despite the acknowledged importance of reading to children, only 45% of children below the age of 3 and 56% of 3- to 5-year-olds were read to daily during 1995-1996 (see Exhibit 5). Parents who had completed higher levels of education were more likely to report that they read to their preschoolers daily.

Exhibit 5: Family-Child Reading

Percentage of children whose parents read to them every day, 1995-1996



See pp. 35-36 for definitions, sources, and technical notes.

During 1995-1996, 45% of all children aged 2 and younger and 56% of all 3- to 5-year-olds were read to daily by parents or other family members.

Indicator 6. Other Family-Child Language and Literacy Activities

Telling stories is another important way that parents can participate in shared literacy activities with their children. In fact, in some cultures storytelling and oral traditions play a more central role than reading books aloud.[11] Visiting a library is another beneficial early language and literacy activity that preschoolers can do with their families. Yet in 1996, fewer than 6 out of 10 children aged 3 to 5 were told stories regularly by their parents, and fewer than 4 out of 10 had visited a library on a regular basis (see Exhibit 6). Parents with higher levels of education were more likely to do both types of literacy activities with their preschool-aged children regularly.

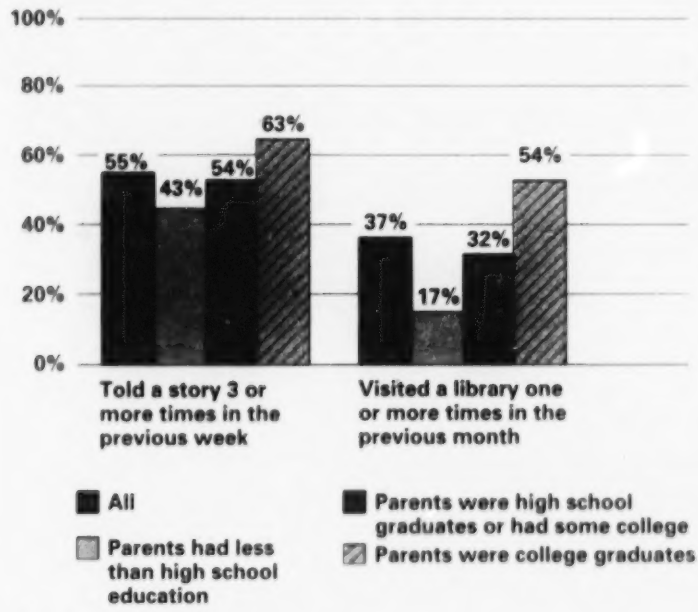
Some reading experts argue that successful achievement of Goal 1 is contingent upon achievement of the second National Education Goal (increasing the high school completion rate) and the sixth National Education Goal (increasing the proportion of adults who are literate). In other words, if we do not simultaneously increase the educational levels and reading skills of parents, then we cannot possibly hope to improve the school readiness of children.

A number of recent studies provide strong support for this argument. In 1996, parents who were college graduates reported that they read daily to their preschool-aged children at more than twice the rate of parents with less than a high school education.[12] Moreover, college-educated parents were more than three times as likely to report that they had recently taken their 3- to 5-year-olds to the library. National reading achievement results from 1992 found that students in Grades 4, 8, and 12 whose parents had completed higher levels of education consistently outperformed classmates whose parents did not have a high school diploma.[13]

Most revealing is the fact that parents' educational attainment continues to be a strong predictor of reading and writing abilities even after children reach adulthood. On average, adults whose parents had completed high school or beyond scored 1 to 1.5 levels higher on English literacy tasks in 1992 than adults whose parents had never completed high school.[14] If the intergenerational link between parents' educational attainment and children's literacy skills is as strong as these and other studies suggest, approaches that support the development of both adult and child literacy skills may merit increased attention if we are to achieve Goal 1.

Exhibit 6: Other Family-Child Language and Literacy Activities

Percentage of 3- to 5-year-olds whose parents engaged in language and literacy activities with them regularly, 1996



See pp. 35-36 for definitions, sources, and technical notes.

During 1996, 55% of all 3- to 5-year-olds were told stories several times per week, while fewer (37%) visited a library one or more times a month.

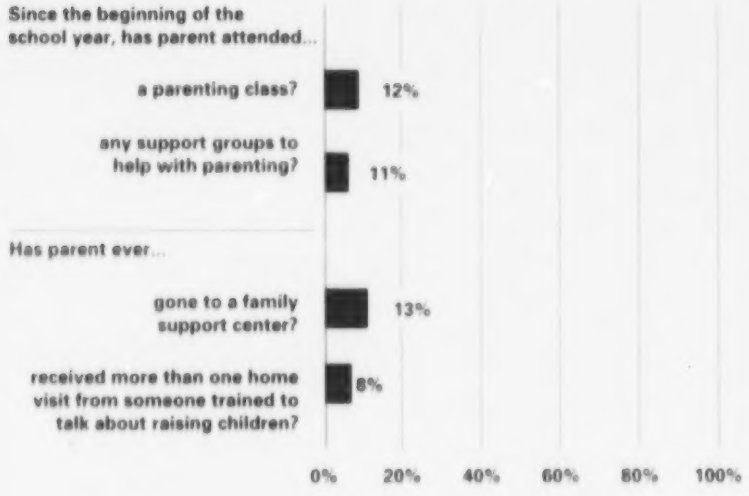
Indicator 7. Support for Families of Preschoolers

The second objective for Goal 1 acknowledges that in order for parents to succeed as their child's first teacher, they should have access to the training and support that they need. Training and support can take many different forms, such as courses taught by pediatric nurses for expectant parents on infant care; support groups offered by local school districts for parents of children with special needs; information distributed by libraries on child development; classes offered by hospitals and YMCAs on emergency CPR and first aid for infants and toddlers; or home visits from social workers, speech and language therapists, or other early childhood professionals.

Relatively few parents of 3- to 5-year-olds participated in these kinds of training and support activities in 1996 (see Exhibit 7). Only 12% reported that they had attended a parenting class since the beginning of the school year, and only 11% reported that they had attended support groups to help with parenting. Thirteen percent reported that they had gone to a family support center, and 8% reported receiving more than one home visit from someone trained to talk about raising children.

Exhibit 7: Support for Families of Preschoolers

Percentage of parents of 3- to 5-year-olds who participated in parent support activities, 1996



See pp. 35-36 for definitions, sources, and technical notes.

In 1996, fewer than one in seven parents of 3- to 5-year-olds participated in parenting classes and other types of parent support activities.

Preschool Experiences

Indicator 8. Preschool Participation

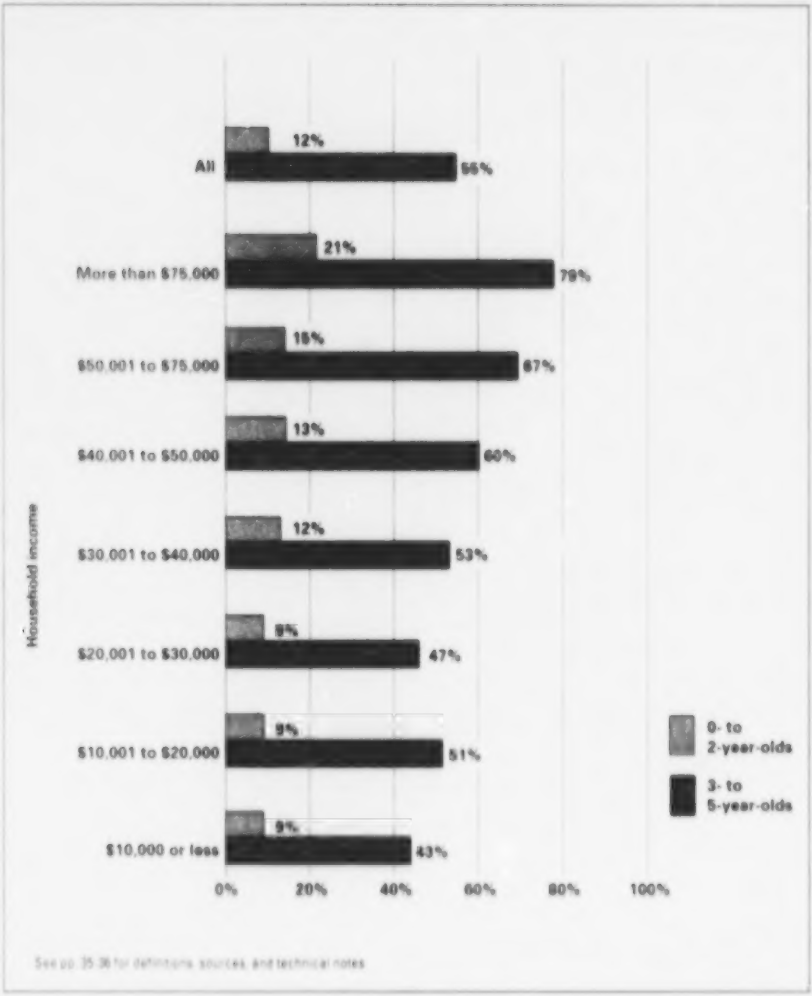
The first objective for Goal 1 specifies that "all children will have access to high-quality and developmentally appropriate preschool programs that help prepare children for school." The goal is not that all 3- to 5-year-olds will attend preschool, because experts agree that the decision to send a child to preschool should be based on informed parental choice. Instead, the goal is to eliminate obstacles to participation for those parents who do want to send their child to preschool. One of the most obvious barriers to participation is family income.

Studies show that high-quality preschool programs can accelerate the development of all children, and poor children in particular.[1] However, children from low-income families are the least likely to attend early care and education programs (see Exhibit 8). In 1996, 55% of 3- to 5-year-olds and 12% of infants and toddlers below age 3 attended preschool. (These percentages include children enrolled in nursery schools, prekindergarten programs, preschools, day care centers, and Head Start, as well as children with disabilities enrolled in preschool. They do not include 5-year-olds enrolled in kindergarten.)

Children from families with household incomes of more than $75,000 attended preschool at roughly twice the rate of children from families with household incomes of $10,000 or less. This was true for 3- to 5-year-olds, as well as for infants and toddlers. Although preschool enrollments have increased over the past twenty years for children regardless of family income, the gap between rich and poor has actually widened over time.

Exhibit 8: Preschool Participation

Percentage of children enrolled in preschool, 1995-1996



See pp. 35-36 for definitions, sources, and technical notes.

During 1995-1996, young children from families with household incomes of more than $75,000 attended preschool at roughly twice the rate of children from families with household incomes of $10,000 or less.

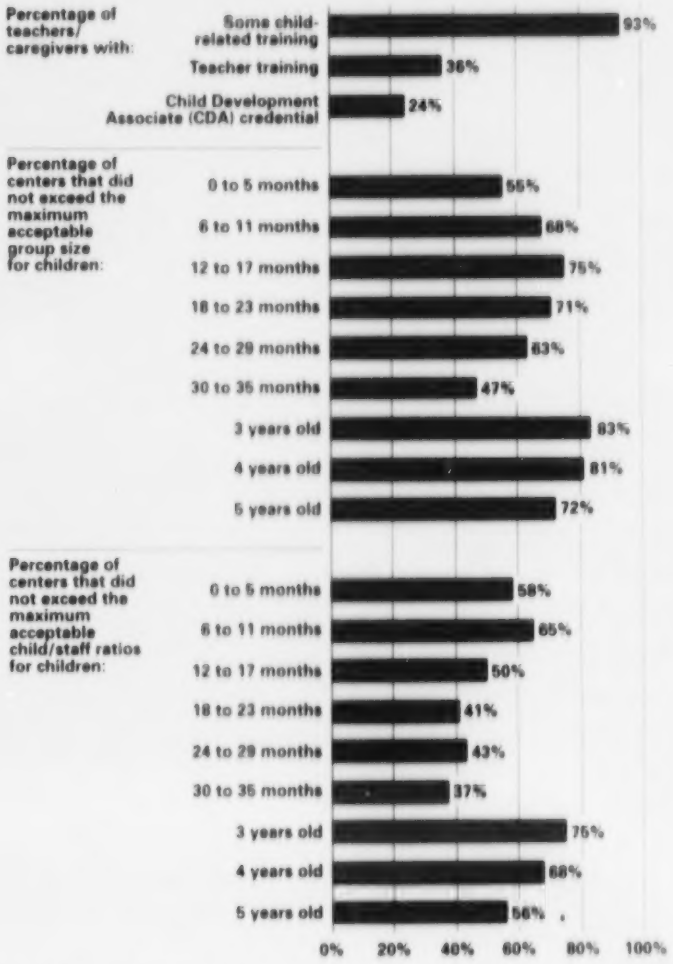
Indicator 9. Quality of Preschool Centers

Enrolling a child in preschool is no guarantee, of course, that he or she will be better prepared for the challenges of formal schooling, unless there is assurance that the preschool program is of high quality. Although we know a great deal about the factors that influence the quality of preschool settings, such as highly trained teachers, low staff turnover, small class size, and low child/staff ratios, we lack a comprehensive, regularly updated, national measure of the quality of preschool care that children are receiving in this country.

More than two-thirds of all states do not require child care center teachers to complete any specialized preservice training, and three-fourths either do not require or do not regulate preservice training for family child care providers.[10] While the majority of preschool center teachers in the United States did have some child-related training in 1990, only about one-third had teacher training, and only one-fourth held a Child Development Associate credential, as recommended by the National Association for the Education of Young Children (see Exhibit 9). Preschool centers were more likely to meet recommended standards of program quality for group size and child/staff ratios for 3- to 5-year-olds than for infants and toddlers. Achieving Goal 1 and ensuring that all children start school ready to learn will require dramatic improvements in both preschool program quality and teacher training.

Exhibit 9: Quality of Preschool Centers

Characteristics of preschool centers and teachers, 1990



See pp. 35-36 for definitions, sources, and technical notes.

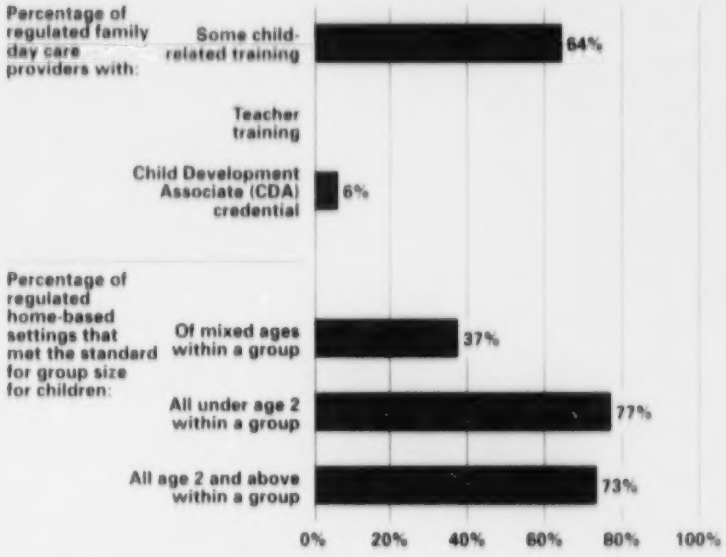
In 1990, preschool centers were more likely to meet recommended standards for group size and child/staff ratios for 3- to 5-year-olds than for infants and toddlers.

Indicator 10. Quality of Home-Based Preschool Settings

Information on the quality of home-based, or family, preschool settings is even more limited than the information available on center-based preschool programs. In 1990, caregivers in home-based preschool settings were less likely than teachers in preschool centers to have child-related training and a Child Development Associate credential (see Exhibit 10). We also know that home-based preschool settings were more likely to meet recommended standards of program quality for group size when children were of similar ages than when children were of mixed ages within a group. However, no information concerning general teacher training and child/staff ratios is available for home-based preschool settings that is comparable to the information collected on preschool centers.

Exhibit 10: Quality of Home-Based Preschool Settings

Characteristics of regulated home-based preschool settings and regulated family day care providers, 1990



See pp. 35-36 for definitions, sources, and technical notes.

Caregivers in home-based preschool settings were less likely than teachers in preschool centers to have child-related training and a Child Development Associate credential.

Conclusions

These data present a statistical snapshot of the well-being of young children. They confirm that current conditions for young children are far from ideal. Too many begin life with avoidable health risks. Too few are regularly engaged in supportive activities at home with their families. And far too many do not have the opportunity to participate in high-quality early care and education programs in safe, caring environments that support their continual development.

It is the shared hope of the National Education Goals Panel and the *I Am Your Child* campaign that by the year 2000, this statistical snapshot will have improved. When the Panel issues its follow-up report, we hope that the combined efforts of the Panel and the *I Am Your Child* campaign will allow us to see many improvements in the well-being of young children, including:

- more mothers receiving early prenatal care;
- fewer infants born at low birthweight or with other kinds of health risks;
- more toddlers who are fully immunized;
- more parents who read and tell stories regularly to their preschool-aged children, and take them to the library;
- more widespread training and support for parents;
- greater access to preschool, especially for low-income families; and
- improvements in the quality of preschool centers and home-based preschool settings.

The Goals Panel urges the public and policymakers to take action and gather information from many sources. A wide array of materials on general education, early childhood education, and state initiatives are available from the organizations listed on the next page.

Additional Sources of Information

I Am Your Child
1010 Wisconsin Avenue, NW
Suite 800
Washington, DC 20007
202-338-4385
http://www.iamyourchild.org

National Education Goals Panel
1255 22nd Street, NW
Suite 502
Washington, DC 20037
202-724-0015
http://www.negp.gov

National Governors' Association
Hall of the States
444 North Capitol Street
Suite 267
Washington, DC 20001-1512
202-624-5330
http://www.nga.org

National Conference of State Legislatures
1560 Broadway
Suite 700
Denver, CO 80202
303-830-2200
http://www.ncsl.org

Bush Center in Child Development and Social Policy
Not By Chance: Creating an Early Care and Education System for American Children
Yale University
310 Prospect Street
New Haven, CT 06511-2188
203-432-9931

Endnotes

1. U.S. Department of Health and Human Services, National Center for Health Statistics. (1990). *Healthy people 2000: National health promotion and disease prevention objectives*. DHHS Publication No. (PHS) 91-50212. Washington, DC: U.S. Government Printing Office.

2. McCormick, M., Gortmaker, S.L., & Sobol, A.M. (1990). Very low birthweight children: Behavior problems and school failure in a national sample. *Journal of Pediatrics* 117(5): 687-693.

3. U.S. Department of Health and Human Services, National Center for Health Statistics. (1992). *Health, United States, 1991, and prevention profile*. DHHS Publication No. (PHS) 92-1232. Washington, DC: U.S. Government Printing Office.

4. Kleinman, J.C., & Kessel, S.S. (1987). Racial differences in low birthweight: Trends and risk factors. *New England Journal of Medicine* 317:749-753.

5. Kleinman, J.C., & Madans, J.H. (1985). The effects of maternal smoking, physical stature, and education attainment on the incidence of low birthweight. *American Journal of Epidemiology* 121(6):843-855.

6. U.S. Department of Health and Human Services, National Center for Health Statistics. (1991). *Healthy people 2000: National health promotion and disease prevention objectives*. DHHS Publication No. (PHS) 91-50212. Washington, DC: U.S. Government Printing Office.

7. United Nations Children's Fund (UNICEF). (1993). *The progress of nations*. New York: author.

8. U.S. Department of Health and Human Services, National Center for Health Statistics. (1992). *Health, United States, 1991, and prevention profile*. DHHS Publication No. (PHS) 92-1232. Washington, DC: U.S. Government Printing Office.

9. United Nations Children's Fund (UNICEF). (1993). *The progress of nations*. New York: author.

10. U.S. Department of Health and Human Services, National Center for Health Statistics. (1992). *Health, United States, 1991, and prevention profile*. DHHS Publication No. (PHS) 92-1232. Washington, DC: U.S. Government Printing Office.

11. Heath, S.B. (1983). *Ways with words*. Cambridge: Cambridge University Press.

12. U.S. Department of Education, National Center for Education Statistics. (1996). *National Household Education Survey (NHES): 1996 parent interview*. unpublished tabulations prepared by Westat, June 1997.

13. Mullis, I., Campbell, J.R., & Farstrup, A.E. (1993). *NAEP 1992 reading report card for the nation and the states*. Report prepared by Educational Testing Service under contract with the National Center for Education Statistics, U.S. Department of Education. Washington, DC: U.S. Government Printing Office.

14. Kirsch, I.S., Jungeblut, A., Jenkins, L., & Kolstad, A. (1993). *Adult literacy in America: A first look at the results of the National Adult Literacy Survey*. Report prepared by Educational Testing Service under contract with the National Center for Education Statistics, U.S. Department of Education. Washington, DC: U.S. Government Printing Office.

15. See Kagan, S.L., & Cohen, N.E. (1997). *Not by chance: Creating an early care and education system for America's children*. New Haven, CT: Bush Center in Child Development and Social Policy, Yale University.

16. Morgan, G., et al. (1993). *Making a career of it*. Boston: Wheelock College, Center for Career Development in Early Education. (as reported in Children's Defense Fund. (1994). *The state of America's children: 1994 yearbook*. Washington, DC: author.)

Notes and Sources for Part 2 Exhibits and Tables

Exhibit 1 and Table 1: Prenatal Care

Prenatal care refers to the first visit for health care services during pregnancy.

Race/ethnicity refers to the race of the mother. Data for Blacks and Whites do not include Blacks or Whites of Hispanic origin. Data for Hispanics are shown only for states with an Hispanic-origin item on their birth certificates.

Source: U.S. Department of Health and Human Services, unpublished tabulations from Division of Vital Statistics, National Center for Health Statistics; prepared by Westat, Inc., July 1997.

Exhibit 2 and Table 2: Birthweight

Race/ethnicity refers to the race of the mother. Data for Blacks and Whites do not include Blacks or Whites of Hispanic origin. Data for Hispanics are shown only for states with an Hispanic-origin item on their birth certificates.

Source: Ibid.

Exhibit 3 and Table 3: Children's Health Index

Risks are late (in third trimester) or no prenatal care; low maternal weight gain (less than 21 pounds); mother smoked during pregnancy; or mother drank alcohol during pregnancy. The National Center for Health Statistics notes that alcohol use during pregnancy, which is one of the measures used by Westat, Inc., to calculate the Children's Health Index, is likely to be underreported on the birth certificate.

Data for Blacks and Whites do not include Blacks or Whites of Hispanic origin.

The percentages of infants at risk are based on the number of births used to calculate the health index, not the actual number of births. The percentage of complete and usable birth records used to calculate the 1995 health index varied from a high of 99.78% to a low of 69.24%. Four states (California, Indiana, New York, and South Dakota) did not collect information on all four risks in 1995. These states and the territories are not included in the U.S. total.

Source: Nicholas Zill and Christine Winquist Nord of Westat, Inc., developed the concept of the Children's Health Index. Stephanie Ventura and Sally Clarke of the National Center for Health Statistics provided the special tabulations of the 1995 birth certificate data needed to produce the index, July 1997.

Exhibit 4 and Table 4: Immunizations

For this purpose, two-year-olds are defined as children 19 to 35 months of age.

The percentage of immunizations for measles/mumps/rubella is one dose of measles or measles/mumps/rubella vaccine. The percentage for diphtheria-tetanus-pertussis/diphtheria-tetanus is three or more doses of vaccine. The percentage for polio is three or more doses of vaccine. Complete immunizations include four doses of diphtheria-tetanus-pertussis vaccine, three doses of polio vaccine, and one dose of measles or measles/mumps/rubella vaccine.

Source: Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, July 25, 1997.

General Notes for Exhibits 5-8

The percentage of children excludes those enrolled in kindergarten.

"Parents" includes the child's parent or another family member.

Data for 0- to 2-year-olds are from the 1995 National Household Education Survey (NHES); data for 3- to 5-year-olds are from the 1996 NHES. Age from the 1995 survey was established as of December 31, 1994. Age from the 1996 survey was established as of December 31, 1995.

BEST COPY AVAILABLE

Exhibit 5: Family-Child Reading

Source: U.S. Department of Education, National Center for Education Statistics, National Household Education Survey: 1996 Parent Interview and 1995 Program Participation Interview, unpublished tabulations prepared by Westat, Inc., June 1997.

Exhibit 6: Other Family-Child Language and Literacy Activities

Data for 0- to 2-year-olds were not available for either the "told story" or "visited library" items.

Source: U.S. Department of Education, National Center for Education Statistics, National Household Education Survey: 1996 Parent Interview, unpublished tabulations prepared by Westat, Inc., June 1997.

Exhibit 7: Support for Families of Preschoolers

Source: Ibid.

Exhibit 8: Preschool Participation

Preschool includes nursery schools, prekindergarten programs, preschools, day care centers, and Head Start (3- to 5-year-olds only).

Source: U.S. Department of Education, National Center for Education Statistics, National Household Education Survey: 1996 Parent Interview and 1995 Program Participation Interview, unpublished tabulations prepared by Westat, Inc., June 1997.

Exhibit 9: Quality of Preschool Centers

The term "preschool centers" includes all licensed center-based early education and care programs, as well as religious-sponsored, part-day, and school-based preschool programs that are exempt from licensing. Licensed before- and after-school programs are not included.

A Child Development Associate (CDA) credential is awarded by the Council for Early Childhood Professional Recognition, National Credentialing Program to individuals who have demonstrated competency in six established goal areas. Within a center-based setting, a person who demonstrates competence working with children aged 3 to 5 is a CDA with a Preschool Endorsement. The National Association for the Education of Young Children (NAEYC) recommends that staff in charge of a group of preschool children have at least a CDA credential or an associate degree in Early Childhood Education/Child Development.

The maximum acceptable group size recommended by the National Association for the Education of Young Children (NAEYC) is 8 for infants, 12 for 1- to 2-year-olds, and 20 for 3- to 5-year-olds.

The maximum acceptable child/staff ratio is 10 children per staff member for groups containing 3- to 5-year olds only; 6 children per staff member for groups containing 2-year-olds only; and 4 children per staff member for groups containing infants and 1-year-olds only. NAEYC standards include an acceptable range of practice on these variables. The figures reported are based on the maximum acceptable numbers, rather than the optimal numbers. Some states also set their own standards in these areas.

Source: Ellen Eliason Kisker, Sandra L. Hofferth, and Deborah A. Phillips, Profile of Child Care Settings Study: Early Education and Care in 1990, submitted to the U.S. Department of Education, Office of Planning, Budget, and Evaluation (Princeton, NJ: Mathematica Policy Research, Inc., 1991), and unpublished tabulations, 1992.

Exhibit 10: Quality of Home-Based Preschool Settings

Regulated home-based preschool settings include all family day care programs that are registered, certified, or licensed by state or county government agencies.

Data on teacher training for regulated family day care providers are not available.

The standard for group size recommended by Health, Education, and Welfare Day Care Requirements for regulated family day care providers without helpers who care for children who are all under age 2 within a group is 3. The group size standard for all children aged 2 and above within a group is 6, and the standard for a group of children of mixed ages within a group is 5.

See technical note regarding the Child Development Associate (CDA) credential under Exhibit 9.

Source: Ibid.

Other Publications for Parents, Educators, and Policymakers

Publications sponsored by the National Education Goals Panel:

National Education Goals Panel. (1997) *Getting a good start in school*. Washington, DC: U.S. Government Printing Office. National Education Goals Panel, 1255 22nd Street, N.W., Suite 502, Washington, DC 20037; 202-724-0015. Free.

Kagan, S.L., Moore, E., & Bredekamp, S. (Eds.) (1995, June) *Reconsidering children's early development and learning: Toward common views and vocabulary*. National Education Goals Panel, Goal 1 Technical Planning Group Report 95-03. 1255 22nd Street, N.W., Suite 502, Washington, DC 20037; 202-724-0015. Free.

National Education Goals Panel. (1997). *The National Education Goals report: Building a nation of learners*. Washington, DC: U.S. Government Printing Office. Free.

National Education Goals Panel. (1997). *The National Education Goals report summary: Mathematics and science achievement for the 21st century*. Washington, DC: U.S. Government Printing Office. Free.

National Education Goals Panel. (1996). *The National Education Goals report executive summary: Commonly asked questions about standards and assessments*. Washington, DC: U.S. Government Printing Office. Free.

National Education Goals Panel. (1995). *The National Education Goals report executive summary: Improving education through family-school-community partnerships*. Washington, DC: U.S. Government Printing Office. Free.

Other:

Barclay, K., & Boone, E. (1991). *Building a three way partnership: The leader's role in linking school, families and community*. New York: Scholastic, Inc. A research-based book that offers specific, practical strategies for home-school communication, parent education, and volunteerism; also includes integrated approaches to assessment and an annotated bibliography of staff and parent resources.

Boyer, E. (1991). *Ready to learn: A mandate for the nation*. Princeton, NJ: Carnegie Foundation for the Advancement of Teaching. A blueprint for action for the readiness of all young Americans.

Decker, L.E., Gregg, G.A., & Decker, V.A. (1994). *Getting parents involved in their children's education*. American Association of School Administrators, 1801 North Moore Street, Arlington, VA 22209; 703-528-0700. A short book focusing on the strategies to initiate parent involvement and volunteerism in the schools, build partnerships between children's homes and schools, and provide learning activities at home for children and their families.

Early childhood education and the elementary school principal: Standards for quality programs for young children. (1990). National Association of Elementary School Principals, 1615 Duke Street, Alexandria, VA 22314-3483; 703-684-3345. Developed for and by principals, this book offers 28 standards for early childhood programs; suggests classroom settings and curriculum; and describes roles of the principal, staff, and parents.

Every child ready for school: Report of the Action Team on School Readiness. (1992). National Governors' Association, Hall of the States, 444 North Capitol Street, N.W., Washington, DC 20001-1512; 202-624-5300. This guide for policymakers identifies the factors that enhance school readiness; suggests benchmarks for states to use as interim measures in their progress towards achieving the goal of ensuring that every child is prepared to start school; and offers a sampling of state initiatives that have been implemented to work toward that goal.

Fair Tests Publications. *Assessment of young children*. National Center for Fair & Open Testing, 342 Broadway, Cambridge, MA 02139. 617-864-4810. An annotated bibliography of books, papers, journal articles, and organizations and projects related to the assessment of children below grade three.

Helping your child get ready for school. (1992). Office of Educational Research and Improvement, U.S. Department of Education. ACCESS ERIC, 1600 Research Boulevard, Rockville, MD 20850; 1-800-USE-ERIC. One in a series of books on education topics relating to the National Education Goals, this parent-oriented guide discusses what school readiness is and provides examples of activities and interactions that help children get ready for school.

Kagan, S.L. (1994) "Readying schools for young children: Polemics and priorities." *Phi Delta Kappan*. Phi Delta Kappa, 408 N. Union, P.O. Box 789, Bloomington, IN 47402; 812-339-1156. An article on the importance of policymakers confronting the polemics raised by past and present reform efforts; shedding ambivalence regarding the role of schooling in American society; and dealing head on with action priorities to enable schools and communities to prepare children effectively for school.

Kagan, S.L., & Cohen, N.E., (1997). *Not by chance: Creating an early care and education system for America's children*. New Haven, CT: Bush Center in Child Development and Social Policy, Yale University.

Katz, L.G. (1992). "Readiness: Children and their schools." *The ERIC Review*. U.S. Department of Education. ACCESS ERIC, 1600 Research Boulevard, Rockville, MD 20850; 1-800-USE-ERIC. Readiness is the focus of this issue, which includes several useful articles, resources, and a reading list.

Laying the foundation for school success: Recommendations for improving early learning programs. (1992). Maryland Commission on the Early Learning Years, Maryland State Department of Education, 200 West Baltimore Street, Baltimore, MD 21201; 410-767-0100. Report of a two-year Commission study that looks at making children's early experiences responsive to their characteristics and building home-school-community partnerships that promote young children's school success.

Moving America to the head of the class: 50 simple things you can do. (1994). Education Excellence Partnership, 1615 L Street, N.W., Suite 1100, Washington, DC 20036; 1-800-USA-LEARN. A brief booklet listing things that parents, employers, teachers, principals, administrators, and other concerned persons can do to promote children's readiness and help America reach the National Education Goals.

Ready or not: What parents should know about school readiness (revised). (1995). Washington, DC: National Association for the Education of Young Children; 1-800-424-2460. A brochure to help parents find "ready schools" and give their children a solid foundation for school success.

*READY*SET*READ early childhood learning kit*. Available from the U.S. Department of Education's OnLine Library: http://www.ed.gov/inits/americareads/. To order a paper copy, please call 1-800-USA-LEARN.

Testing of young children: Concerns and cautions. (1988). National Association for the Education of Young Children, 1509 16th Street, N.W., Washington, DC 20036; 1-800-424-2460. For parents and teachers, a layperson's version of NAEYC's position statement on standardized testing of children aged 3 through 8.

Your child goes to school: A handbook for parents of children entering school for the first time (revised). (1995). Maryland State Department of Education, 200 West Baltimore Street, Baltimore, MD 21201; 410-767-0100. A booklet for parents that addresses common questions such as: "How do I handle opening day jitters?" "Will my child be tested?" and "What activities will help my child succeed?"

Goal 1 Advisors to the National Education Goals Panel

Technical Planning Group on Readiness for School

Leader: Sharon Lynn Kagan, Yale University

Sue Bredekamp, National Association for the Education of Young Children
M. Elizabeth Graue, University of Wisconsin
Luis Laosa, Educational Testing Service
Samuel Meisels, University of Michigan
Evelyn Moore, National Black Child Development Institute
Lucile Newman, Brown University
Lorrie Shepard, University of Colorado
Valora Washington, The Kellogg Foundation
Nicholas Zill, Westat, Inc.

Goal 1 Early Childhood Assessments Resource Group

Leaders: Sharon Lynn Kagan, Yale University
Lorrie Shepard, University of Colorado

Sue Bredekamp, National Association for the Education of Young Children
Edward Chittenden, Educational Testing Service
Harriet Egertson, Nebraska State Department of Education
Eugene García, University of California, Berkeley
M. Elizabeth Graue, University of Wisconsin
Kenji Hakuta, Stanford University
Carollee Howes, University of California, Los Angeles
Luis Laosa, Educational Testing Service
Annemarie Palincsar, University of Michigan
Tej Pandey, California State Department of Education
Catherine Snow, Harvard University
Maurice Sykes, District of Columbia Public Schools
Valora Washington, The Kellogg Foundation
Nicholas Zill, Westat, Inc.

Goal 1 Ready Schools Resource Group

Leaders: Asa Hilliard, Georgia State University
Sharon Lynn Kagan, Yale University

Barbara Bowman, Erikson Institute
Cynthia Brown, Council of Chief State School Officers
Fred Brown, Boyertown Elementary School
Linda Espinosa, University of Missouri
Donna Foglia, Norwood Creek School
Peter Gerber, MacArthur Foundation
Sarah Greene, National Head Start Association
Judith Heumann, U.S. Department of Education
Mogens Jensen, National Center for Mediated Learning
Lilian Katz, ERIC Clearinghouse for Elementary and Early Childhood Education
Michael Levine, Carnegie Corporation of New York
Evelyn Moore, National Black Child Development Institute
Tom Schultz, National Association of State Boards of Education
Barbara Sizemore, DePaul University
Robert Slavin, Johns Hopkins University

Typography and design by the U.S. Government Printing Office and Westat
Editorial assistance provided by Scott Miller, Editorial Experts, Inc.

BEST COPY AVAILABLE